MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH

07600

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in this community (yrs., mos., or days) 1

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State — (b) County —

(c) City or town — (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mary Frances Baby Aldridge

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1939

8. AGE: Years | Months | Days | If less than one day 16 hr. & 40 min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name H Reford Aldridge

13. Birthplace Mount Savage Md

MOTHER

14. Maiden Name Margaret B Wolfe

15. Birthplace Forrest Glenn Md

16 (a) Informant H Reford Aldridge

(b) Address Frostburg Md

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug (month) 8 (day) 1939 (year)

(c) Cemetery ~~or crematory~~ St. George

Location Mt. Savage

18 (a) Funeral director J. J. Durst

(b) Address Frostburg Md

19 (a) 8 – 8 '39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 7 1939, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1939, to Aug 7 1939, and that I last saw him alive on Aug 7 1939.

Immediate cause of death: Respiratory Paralysis — Duration 16 hrs

Due to umbilical cord around neck

Due to at Childbirth

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature W. D. McLane Jr. M.D. M. D. or other

Address Frostburg Md Date signed Aug 7 '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 1 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

07601

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 411 Lehigh

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 411 Lehigh Cumb - Md
(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Katherine M Alsip

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~ Reamer H Alsip

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Dec 20 1855

8. AGE: Years 73 Months 7 Days 17 If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Conrad Gatting
13. Birthplace Germany

MOTHER
14. Maiden name Anna E. Smith
15. Birthplace Germany

16. Informant Reamer H Alsip

Address 411 Lehigh - Cumb. Md.

17. ~~Hill Crest~~ Date thereof Aug 9 1939
(Burial, ~~cremation, or removal. Which?~~) (month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address 117 Frederick St

19. Aug 8, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Koon.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1939, at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1939, to Aug 7 1939, and that I last saw her alive on Aug 5 1939.

Immediate cause of death: Uremia Coma — DURATION 2 Days

Chronic Nephritis — 4 yrs

Due to Organic Heart Disease — 4 yrs

Due to Arterial Sclerosis — 4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. W. Koon M. D. ~~or other~~

Address Cumberland Md Date signed Aug 8-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07602

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ALLEGANY HOSPITAL.

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PA. County ALLEGHENY

City or town PITTSBURG Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 132 JOHN ST. REAR.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME BABY BOY HUGUSTINE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-39

8. AGE: Years | Months | Days | If less than one day: hrs. 15 min.

9. Birthplace CUMBERLAND MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name RICHARD JAMES HUGUSTINE
13. Birthplace PITTSBURG, PA.

MOTHER
14. Maiden name CAROLINE ESTELLA CEYROLLES
15. Birthplace IMPERIAL, PA.

16. Informant MRS. CAROLINE HUGUSTINE
Address 132 JOHN ST. REAR. PITTSBURG PA.

17. buried (Burial, cremation, or removal. Which?) Date thereof Aug 7, 1939 (month) (day) (year)

Cemetery or crematory St. Peter & Paul's Cem.

Location Cumberland, Md.

18. Funeral director Family.

Address

19. Aug 7, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 19 39, at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at birth, to 19, and that I last saw h alive on 19.

Immediate cause of death	DURATION
Prematurity	
Due to (Mother had fall 7-4-39.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. C. Bowen M.D.
M. D. or other

Address Cumberland Date signed 8-7-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

M

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07603

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 220 S. Smallwood, St.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Premature Boy Bivens Stillborn

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced ~~married~~ Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1939.

8. AGE Years Stillborn Months Days If less than one day hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Mr. Wilbert J. Bivens
13. Birthplace Martinsburg, W. Va

MOTHER
14. Maiden name Meta V. Sibole
15. Birthplace Martinsburg, W. Va

16. Informant Allegany Hosp.
Address Cumberland, Md

17. Burial Date thereof Aug. 30, 1939
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Allegany Co. Cem.

Location Cumberland, Md.

18. Funeral director Jacob Hafer
Address Cumberland

19. Aug. 29 1939 J. P. Franklin, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1939, to Aug 26 1939, and that I last saw him alive on Aug 1939.

Immediate cause of death Stillborn

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Ew Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 133 Va Ave Date signed Aug 27 39

RECEIVED
SEP 8 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 9

07604

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town ~~Mt Savage~~ Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town) Still Born

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Infant Blank

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Still Born

8. **AGE:** Years | Months | Days | If less than one day hr. min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Wm L Blank

13. Birthplace Md

MOTHER 14. Maiden Name Tilliay V. Michaels

15. Birthplace Md

16 (a) Informant Wm L Blank

(b) Address Mt Savage Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 39 (month) (day) (year)

(c) Cemetery or crematory St Patricks

Location Mt Savage Md

18 (a) Funeral director J. J. Dirrett

(b) Address Frostburg

19 (a) 8-23-39 (Date rec'd by registrar) (b) Mrs A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 23 1939, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw him alive on 19.

Immediate cause of death Still Born

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Bostetter MD M. D. or other

Address Mt Savage Md Date signed 8-23-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 1 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07605

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (81)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 328 Fayette St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany.

City or town Cumberland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 328 Fayette St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Bohn

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1852.

8. AGE:

Years	Months	Days	If less than one day
86	7	23	hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business

FATHER
12. Name William Bohn.
13. Birthplace Germany.

MOTHER
14. Maiden name Mary Blank.
15. Birthplace Germany.

16. Informant Miss Sokhie Bowen

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14 39. (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland. Md.

19. Aug 12 1939 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

36 Green Snyder

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11. 1939, at 11:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5. 1939, to Aug 11. 1939, and that I last saw him alive on Aug. 14. 1939.

Immediate cause of death Multiple Spinal Sclerosis — DURATION 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. F. W. Snyder M. D. or other

Address Cumberland Md Date signed 8-12-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (748)

07606

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 53

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Gilmore, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John A. Bond

3. (b) Social Security Number 214-01-6690.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hannah J. Moore Bond

6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1885

8. AGE:

Years	Months	Days	If less than one day
53	11	5	——hrs. ——min.

9. Birthplace Frostburg, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mine

FATHER — 12. Name John Bond

FATHER — 13. Birthplace England

MOTHER — 14. Maiden name —

MOTHER — 15. Birthplace —

16. Informant John F. Bond

Address R.F.D. 1 Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 1939 (mopth) (day) (year)

Cemetery or crematory Allegany

Location Frostburg Md.

18. Funeral director M. E. Dickerson

Address Lonaconing Md

19 August 30 1939 (Date rec'd by registrar) Dr. E. Dow Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29th 1939, at 11.10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——19——, to ——19——, and that I last saw h——elive on ——19——.

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide —— Date of ——

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work?

23. SIGNATURE Pierce H. Bouton, M.D.
M. D. or other

Address Cumberland, Md. Date signed 8-29-1939

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07607

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(96)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 106 North Allegany Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 106 North Allegany St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: THOMAS J. BRENNAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Annie Greenwood

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15 1877

8. AGE: Years: 62 Months: 4 Days: 12 If less than one day: hrs. min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Life Insurance Agent

11. Industry or business: Equitable Life Assurance Soc.

FATHER
12. Name: Thomas Brennan
13. Birthplace: England

MOTHER
14. Maiden name: Bridget (Maiden name not known)
15. Birthplace: England

16. Informant: Thomas Herman Brennan

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16 '39 (month) (day) (year)

Cemetery or crematory: Sts Peter & Paul's Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Sept 15 1939 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27th 1939, at 9P.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death: Hemoptysis

DURATION: 1 hour

Due to:

Due to:

Other conditions: Aneurism, probably arch of aorta.
(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis H. Larson, M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 8-30-'39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Thomas J. Brennan

RECEIVED
SEP 23 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

07608

(131)

1. PLACE OF DEATH

County Allegany Registration Dist. No. 4

Village or City Cumberland No. 407 Bedford St., 4-2 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Josephine M. Buckholtz If U. S. Veteran, specify WAR

(a) Residence: No. 407 Bedford St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) July 21 1851

7. AGE: Years 88 Months 0 Days 24 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housekeeper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Christopher Buckholtz

14. BIRTHPLACE (city or town) (State or country) Germany.

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address) Frank A. Buckholtz Cumberland

18. BURIAL, CREMATION, OR REMOVAL Place Hillcrest Cem. Date Aug 18, 1939

19. UNDERTAKER (Address) Louis Stein Inc. Cumberland

20. FILED Aug. 18, 1939 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug. (Month) 15 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 4, 1939, to Aug 15, 1939

I last saw her alive on Aug 13, 1939; death is said to have occurred on the date stated above, at 70 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Organic Heart Disease	1935
Chronic Myocarditis	
Dilated Heart	

Other Contributory Causes of importance:

Chronic Nephritis	1935

Name of operation Date of

What last confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Geo. A. Koon M. D.

(Address) Cumberland Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIM

(157-c)

CERTIFICATE OF DEATH

07609

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 167 Spring St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 167 Spring St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Clarence Chaney Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Child.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1939.

8. AGE: Years 4 Months Days 22 If less than one day hrs. min.

9. Birthplace Frostburg, Md.

(Town, county, and state)

10. Usual occupation Child.

11. Industry or business

FATHER 12. Name Clarence Chaney Sr

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Pauline Milne

15. Birthplace Elkins, W. Va.

16. Informant Clarence Chaney Sr.

Address 167 Spring St - Frostburg Md

17. Burial St. Michaels Cem Date thereof Aug 20, 1939.

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 8-20 1939 Reg. J. R. Walker

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1939, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 28 1939, to Aug 19 1939, and that I last saw him alive on Aug 19 1939.

Immediate cause of death Congenital Malformation of Heart — DURATION: Life

Due to

Due to

Other conditions Congenital Malformation

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. McFarland M.D.

M. D. or other

Address Frostburg Md. Date signed Aug 20 39

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07610

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(167)

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: ~~Mt Savage~~ Maryland County: Allegany

City or town: Mt Savage Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Louisa M. Chisholm

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dallas Chisholm

6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Aug 1 - 1878

8. AGE: Years: 61 Months: — Days: 13 If less than one day: hrs. min.

9. Birthplace: Mt Savage, Alleg - Md (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER: 12. Name: George A. Uhl

13. Birthplace: Wellersburg Pa.

MOTHER: 14. Maiden name: Jane Wilson

15. Birthplace: Mt Savage, Md

16. Informant: Dallas Chisholm

Address: Mt Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 17 - 1939 (month) (day) (year)

Cemetery or ~~crematory~~: St. George

Location: Mt Savage, Md.

18. Funeral director: J J Durst

Address: Frostburg, Md.

19. Aug 15 1939 (Date rec'd by registrar) H. J. Hostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14th 1939, at 10.30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: suicide by gun-shot. (12 gauge shot gun)

Due to

Due to

Other conditions: Mental aberration 3 months

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

~~Accident~~, suicide, ~~or homicide~~: suicide Date of: 8-14-39

Where did injury occur? Mt. Savage, Allegany Md. (City or town) (County) (State)

Injured at home, ~~farm, industry, public place (where?)~~: home

Means of injury: shot gun Injured at work? no

23. SIGNATURE: Lennie H. Corson, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 8-14-39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07611

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

1. PLACE OF DEATH:

County Allegany

City or town Westernport. Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 58-6-24

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Westernport, Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2 miles East of Westernport
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Harrison Clarke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alda Clark

6(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1881

8. AGE:

Years	Months	Days	If less than one day
58	6	24	____ hrs. ____ min.

9. Birthplace Barton, Allegany, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

FATHER
12. Name Jefferson Clark
13. Birthplace Md.

MOTHER
14. Maiden name Henrietta Michaels
15. Birthplace Barton, Md.

16. Informant Edgar Clark

Address Barton, Md.

17. Buried Date thereof Aug 17, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill.

Location Moscow, Md.

18. Funeral director D. S. Boyle

Address Westernport, Md.

19. Aug 16 1939 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1939, at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1939, to Aug 15 1939, and that I last saw him alive on Aug 14 1939

Immediate cause of death Sarcoma Arising

DURATION 8 mo

Due to from Fissure of Rectum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman Reece MD
M. D. or other

Address Westernport Md Date signed 8/15/39

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WITHIN CORPORATE LIMITS

07612

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (71-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 6

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town KEYSER Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 84 MAIN ST.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME LYDIA ANN COHEN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 29, 1939

8. AGE: Years | Months 4½ | Days 25 | If less than one day hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name SAMUEL COHEN
13. Birthplace ARKANSAS

MOTHER
14. Maiden name EVELYN HOOVER
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. R Burial (Burial, cremation, or removal. Which?) Date thereof 5-26-39 (month) (day) (year)

Cemetery or crematory Evens Pt.

Location Keyser - W. Va.

18. Funeral director J. A. Rogers Funeral Director

Address Keyser, W. Va.

19. Aug. 25 1939 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 24, 1939, at 9:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to AUG. 24, 1939, and that I last saw her alive on AUG. 24, 1939.

Immediate cause of death Idiopathic Aplastic Anemia — DURATION Aug-1-39

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Eliason MD
M.D. or other

Address 126 Union St. Cumberland Md. Date signed Aug. 24-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR.

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SEP 6 1939
BUREAU V. S.

Outside of City Limits

CORPORATE LIMITS.

07613

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(183)

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural - Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 604 Elm St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Donald DeWalt Counihan

3. (b) Social Security Number

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced Child.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1938

8. AGE: Years 1 Months 7 Days 8 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Michael Joseph Counihan
13. Birthplace Cumberland Md.

MOTHER
14. Maiden name Clara Miller
15. Birthplace Altoona, Pa

16. Informant Michael J. Counihan
Address 604 Elm St - Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug 25, 1939
(month) (day) (year)

Cemetery ~~or crematory~~ Hill Crest

Location Cumberland

18. Funeral director Jacob Hafer.
Address Cumberland Md.

19. Aug. 25 1939 J. P. Frank Clin. Mgr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22nd 1939, at 9 55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19

Immediate cause of death accidental drowning

Due to fall into cistern

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, ~~suicide~~, or ~~homicide~~ accident Date of 8-22-1939

Where did injury occur? near Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) on farm of an aunt.

Means of injury drowning Injured at work? no

23. SIGNATURE Linne H. Corson, M. D.
M. D. or other

Address Cumberland, Md. Date signed 8-22-1939

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

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SEP 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07614

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 months
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 214 North Mechanic Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: HEZEKIAH CONRAD

3. (b) Social Security Number: 214-05-9555

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 25, 1874

8. AGE: Years 64 | Months 11 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Locksmith
11. Industry or business: own business

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Allegany Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 14, 1939 (month) (day) (year)
Cemetery or crematory: ~~Allegany County~~ Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Aug 12, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

H. Green, Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1939, at 6:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1939, to Aug 10 1939, and that I last saw in alive on Aug 9 1939.

Immediate cause of death: Acute Dilatation of Heart
Due to: Chronic Myocarditis
Due to: Chronic Nephritis
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION: 6 mos; 8 mos

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: F. Allan E. Hennessy M.D. M.D. or other
Address: 41 Green St Cumberland Md Date signed: Aug 11/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07615

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 201 Race Street
Stay in hospital or inst. (yrs., or mos., or days): --
Stay in this community (yrs., or mos., or days): 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 201 Race Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: HATTIE MAY ROYCE COOPER

3. (b) Social Security Number: --

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wilbur Clarence Cooper
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): December 26, 1891
8. AGE: Years 47 Months 7 Days 25 If less than one day ____ hrs. ____ min.
9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home
FATHER 12. Name: William H. Royce
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Anna E. Whitaire
15. Birthplace: West Virginia
16. Informant: Wilbur Clarence Cooper
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23, 1939 (month) (day) (year)
Cemetery or crematory: Indian Mound Cemetery
Location: Romney, West Virginia
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Aug. 23, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21 1939, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1939, to Aug. 21 1939, and that I last saw h[illegible] alive on Aug. 19 1939
Immediate cause of death: Carcinoma of Chest — DURATION 1937
Due to: Carcinoma of Breast — 1930
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. H. Gleason M.D. M. D. or other
Address: 26 Yuma St., Cumberland Md. Date signed: 8/21/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

07616

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 8
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town GRANTSVILLE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MRS. RACHAEL CUSTER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife STEPHEN CUSTER
6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 7, 1886

8. AGE:

Years	Months	Days	If less than one day
52	9	15	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name DANIEL YOMMER
13. Birthplace MARYLAND

MOTHER
14. Maiden name MARY BROADWATER
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-24-1939 (month) (day) (year)
Cemetery or crematory grantsville Md
Location grantsville Md
18. Funeral director Wm Winebrenner
Address grantsville Md
19. Aug. 24, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 22, 1939, 5:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 14, 1939, to AUG. 22, 1939, and that I last saw h- or- alive on AUGUST 22, 1939

Immediate cause of death	DURATION
Typhoid Fever	2 wks
Due to	
Due to	
Other conditions None	

(Include pregnancy within 8 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Lanich M. D. or other
Address Cumberland Md Date signed 8-22-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. LANICH

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

CERTIFICATE OF DEATH

07617

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Allegany Hospital

Stay in hospital or instl. (yrs., or mos., or days) 10 hrs

Stay in this community (yrs., or mos., or days) 10 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 133 Union St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Dakin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Child

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1939

8. AGE: Years | Months | Days | If less than one day: 10 hrs. min.

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Roy Dakin

13. Birthplace Boston Mass

MOTHER 14. Maiden name Nellie Stanfleet

15. Birthplace Arthur W Va.

18. Informant Roy Dakin

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 16, 1939 (month) (day) (year)

Cemetery or crematory Piney Grove

Location Arthur W. Va.

18. Funeral director Jacob Hofer

Address Cumberland

19 Aug 15 19 39 J. P. Hawkins M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14th 1939, at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14th 1939 to Aug 14th 1939 and that I last saw h[illegible] alive on Aug 14th 1939.

Immediate cause of death	OURATION
Premature birth by Caesarian section	
Due to Bilateral Pyelonephritis	
Due to Mother.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. McLean M.D.

M. D. or other

Address Date signed

RECEIVED
SEP 6 1939
BUREAU V. S.

07618

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Midland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 59 W. Main St.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Olney Francis Dicken

3. (b) Social Security Number 214-10-4729

4. Sex: Male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Goodrich

6(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.): Aug 14, 1902

8. AGE: Years 36 | Months 11 | Days 27 | If less than one day — hrs. — min.

9. Birthplace: Davis W. Va.
(Town, county, and state)

10. Usual occupation: Electrician-Linesman

11. Industry or business: Potomac Edison Co.

FATHER
12. Name: Kelley Dicken
13. Birthplace: Black Valley, Pa.

MOTHER
14. Maiden name: Bessie Bennett
15. Birthplace: Black Valley Pa.

16. Informant: Mrs Olney Dicken
Address: 59 W. Main St Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1939 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: Jacob Hafer
Address: Frostburg, Md.

19 Aug 12 1939 (Date rec'd by registrar) Dr. E. Dr. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11th 1939, at 9.55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Electrocution High Tension Current Lineman - fell on

Due to wires at top of electric light pole -

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ accident Date of 8-11-39

Where did injury occur? near Midland, Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) industry

Means of injury Electric current Injured at work? yes

23. SIGNATURE Linnes H. Larson, M.D.
M. D. or other

Address Cumberland, Md. Date signed 8-11-39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-a)

07619

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 306 GRAND AVE.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ROBERT H. EATON

3. (b) Social Security Number: 236-12-7639

4. Sex: MALE

5. Color or race: WHITE

6. (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAY 29, 1916

8. AGE: Years 23 | Months 2 | Days 29 | If less than one day hrs. min.

9. Birthplace: WEST VIRGINIA Paw Paw
(Town, county, and state)

10. Usual occupation: CELANESE CORPORATION

11. Industry or business

FATHER
12. Name: WHEELER EATON
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: BERTHA AMBROSE
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 8-31, 1939 (month) (day) (year)

Cemetery or crematory: Woodrow Conn.

Location: Woodrow W.Pa.

18. Funeral director: Jacob Hopes

Address: Cumberland

19. Aug 29 1939 (Date rec'd by registrar) J. P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 28, 1939 3:26 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1939, to AUG. 28 1939, and that I last saw him alive on AUG. 28, 1939.

Immediate cause of death: Lymphatic Leukemia in Aleukemic State

DURATION: ???

Due to

Due to

Other conditions: Severe Secondary Anemia

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel H. Jacobson M.D.
M. D. or other

Address: 119 Bedford St Date signed 8/29/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. JACOBSON

RECEIVED
SEP 6 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46-A) CB Reg. Dist. No. 6

07620

CERTIFICATE OF DEATH

1. PLACE OF DEATH

(a) County Allegany Co

(b) City or town Westernport Md (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Reeves Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days

(e) Length of stay in this community (yrs., mos., or days) 75 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State W. Va. (b) County Mineral

(c) City or town Laurel Dale Rural (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years ✓

3 (a) FULL NAME William Frank Ebert

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Pauline (Lemon) Ebert

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1864

8. AGE: Years 75 Months 6 Days 2 If less than one day hr. min.

9. Birthplace Hampshire Co. W.Va. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name John Ebert

13. Birthplace Hampshire Co. W.Va. Germany

MOTHER

14. Maiden Name Lydia Lyon

15. Birthplace Hampshire Co. W.Va.

16 (a) Informant Earl L. Ebert

(b) Address Petersburg, W.Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 29, 39 (month) (day) (year)

(c) Cemetery or crematory Meadow Point Cemetery

Location Keyser, W.Va.

18 (a) Funeral director N. H. Rogers

(b) Address Keyser W.Va.

19 (a) Aug. 28, 1939 (Date rec'd by registrar) [signature] M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 27 1939, at 1245 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1939, to 8-27 1939, and that I last saw him alive on 8-27 1939.

Immediate cause of death	Duration
Primary Carcinoma	
Due to Esophagus	3
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature] M. D. ~~or other~~

Address Westernport Md Date signed 8/27/39

RECEIVED
SEP 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (215-m)

07621

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)

State: Md. County: Allegany

City or town: Eckhart Mines Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Eckhart, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph Fields

3. (b) Social Security Number: 214-01-3591

4. Sex: M | 5. Color or race: W | 6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Laverne Fields

6(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Dec 28-1905

8. AGE: Years: 33 | Months: 7 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Midlothian, Alleg. Md.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: coal mines

FATHER 12. Name: unknown

FATHER 13. Birthplace:

MOTHER 14. Maiden name: May Cross

MOTHER 15. Birthplace: England

16. Informant: Edward Philpot

Address: Frostburg, Md.

17. (Burial, cremation, or removal. Which?): burial Date thereof: aug 25-1939
(month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg

18. Funeral director: J. E. Dusel

Address: Frostburg, Md

19. (Date rec'd by registrar): 8-25 19 39 Registrar: mo. A.R. Walker

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22nd 1939, at 8.50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Fractured skull	
Due to	
Due to	
Other conditions: fracture left radius & ulna Lower 1/3 " " tibia & fibula	

(Include pregnancy within 3 months of death)

Major findings: Lower 1/3

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: accident Date of: 8-22-1939

Where did injury occur? near Frostburg (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: collision auto & motorcycle Injured at work? no

23. SIGNATURE: Frances H. Johnson, M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 8-23-1939

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEA WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 1 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

07622 5

CERTIFICATE OF DEATH

(8)

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cresaptown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Flanagan
3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Infant
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 3, 1939
8. AGE: Years Months Days If less than one day hrs. min.
Stillborn
9. Birthplace Cresaptown, Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Elmer E. Flanagan
13. Birthplace Mill Creek, W. Va.
MOTHER 14. Maiden name Jesse Lea Fox
15. Birthplace Charleston, W. Va.
16. Informant Elmer E. Flanagan
Address Cresaptown Md
17. Burial Date thereof Aug 5, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory West Union, W. Va.
Location
18. Funeral director Jacob Hafer
Address Cumberland Md
19. Aug 4, 1939 M. J. Fauvertin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1939, at 11:20 M P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1939, to Aug 3 1939, and that I last saw her alive on Stillborn Aug 3, 1939.
Immediate cause of death Still birth
Due to Unable to State
Due to Mother High Temperature from Lagrippe
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. F. W. Singer M.D. or other
Address Cumberland Md Date signed 8-4-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 7 1934
BUREAU V. S.

WITHIN CORPORATE LIMITS.

(M)

(S)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07623

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumb. Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Memorial Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Fox, Baby Girl (Stillborn)

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 15, 1939

8. AGE: Years: Stillborn | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland, Maryland, Alleg. Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Fox, David J.
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Bonneville, Pauline
15. Birthplace: Massachusetts

16. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Aug. 18, 1939
(month) (day) (year)

Cemetery or crematory: Edson Cemetery

Location: Lowell, Mass.

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Aug. 16 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1939, at 10:24 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15/39 19 , to Aug 15/39 ,
and that I last saw her ~~alive~~ Dead on Aug 15/39 19 .

Immediate cause of death: Stillborn

Due to Premature (Twins) Anatomic condition of

Due to Mother

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. J. Onsheep M.D.
M. D. or other

Address: 41 - Green - Cumberland Date signed Aug. 15/39

RECEIVED
SEP 6 1938
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07624

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 727 Greene Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Infant FRAME

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 23, 1939

8. AGE: Years	Months	Days	If less than one day
0	0	1	hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER
12. Name: Edward R. Frame
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ethel Miller
15. Birthplace: Maryland

15. Informant: Edward R. Frame
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29, 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Aug. 29 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1939, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1939 to Aug 24 1939, and that I last saw h[illegible] alive on Aug 24 1939.

Immediate cause of death — DURATION

Due to: Prematurity (2 weeks gestation) — 8-23-39

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Arthur T. Jones M.D.
M. D. or other
Address: 40 N. Liberty St. Date signed 8-25-39

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

07625

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Selbysport Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James Frantz

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Fike Frantz

6(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): September 2, 1866

8. AGE: Years 72 Months 11 Days 5 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business:

FATHER
12. Name: Wesley Frantz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ross
15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 10, 1939 (month) (day) (year)

Cemetery or crematory: Bond Springs, Md

Location: Near Tearer, Md.

18. Funeral director: E. G. Horner

Address: Brandonville W Va

19. Aug 9, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1939, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1939, to Aug 7 1939, and that I last saw him alive on Aug 7 1939.

Immediate cause of death: Shock following resection of bowel. DURATION: 6 hrs

Due to: partial obstruction 5 days

Due to: Carcinoma (adeno) of ileum ?

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Lumen of ileum causing obstruction

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. M. Wilson M.D. M.D. or other

Address: Cumberland Md Date signed: 8-7-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

076269

Reg. Dist. No.

1. PLACE OF DEATH:
County Allegany
City or town Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 25 W. Main St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Frostburg Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 25 W. Main St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Trollop Hart

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Clara Chaney
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 15, 1859
8. AGE: Years 79 Months 9 Days 1 If less than one day hrs. min.
9. Birthplace Zihlman, Allegany, Md. (Town, county, and state)
10. Usual occupation Coal Miner
11. Industry or business Coal Mines.
FATHER 12. Name Robert Hart
13. Birthplace England.
MOTHER 14. Maiden name
15. Birthplace
16. Informant Allen Hart
Address Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18, 1939 (month) (day) (year)
Cemetery or crematory Allegany
Location Frostburg Md
18. Funeral director Jacob Hafer
Address Frostburg Md
19. Aug. 28 1939 (Date rec'd by registrar) mrs. A R Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1939, at 2 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1939, to Aug. 16 1939
and that I last saw him alive on May 5 1939
Immediate cause of death Probably acute cardiac dilatation DURATION Unknown
Due to Chronic myocarditis
Due to Died in sleep
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J C Coley M. D. or other
Address Frostburg, Md. Date signed 8-30-39

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (95a)

Reg. Dist. No. 9

CERTIFICATE OF DEATH

07627

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution 187 Mechanic St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 187 Mechanic St. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas Francis Higgins

3 (b) If veteran, name war —

3 (c) Social Security No. 216-05-0560

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mystle Crazer

6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Oct 8-1900

8. AGE: Years 38 Months 9 Days 4 If less than one day hr. min.

9. Birthplace Borden Shaft Md (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Celanese

FATHER 12. Name James Higgins

13. Birthplace Vale Summit, Md.

MOTHER 14. Maiden Name Margret Tippen

15. Birthplace Borden Shaft Md.

16 (a) Informant Mrs Margret Higgins

(b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 1939 (month) (day) (year)

(c) Cemetery or ~~crematory~~ St Michaels

Location Frostburg

18 (a) Funeral director J J Durst

(b) Address Frostburg Md

19 (a) 8-13-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 12, 1939, at 6 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1939, to Aug 12 1939; and that I last saw him alive on Aug 11 1939.

Immediate cause of death Auricular fibrillation with heart block

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration: 1 yr. 2 days.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. E. Gattens M.D. M. D. or other

Address Frostburg, Md. Date signed 8/12/39.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 1 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

07628

1. PLACE OF DEATH (93-C)

County Allegany Registration Dist. No. 4

Village or City Cumberland No. 14 So. Chase St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME H Frank Hull If U. S. Veteran, specify WAR ___

(a) Residence: No. 14 So Chase St., ___ Ward. ___ (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6. DATE OF BIRTH (month, day, and year): Oct 15, 1859

7. AGE: Years 79 Months 9 Days 28 If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or perticular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: X

10. Date deceased last worked at this occupation (month and year): ___

11. Total time (years) spent in this occupation: ___

12. BIRTHPLACE (city or town) (State or country): Ohio

FATHER

13. NAME: Abram Hull

14. BIRTHPLACE (city or town) (State or country): Ohio

MOTHER

15. MAIDEN NAME: Maltilda Armstrong

16. BIRTHPLACE (city or town) (State or country): Ohio

17. INFORMANT (Address): Mrs G. F. Rosamond Cumberland, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Newark, Ohio Date Aug 14, 1939

19. UNDERTAKER (Address): V. L. Lemperton Cumberland Md.

20. FILED Aug 13 1939 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 13 (Day) 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 8/1, 1939 to 8/13, 1939.

I last saw him alive on 8/9 1939; death is said to have occurred on the date stated above, at 2:25 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	8/4/39
Other Contributory Causes of Importance:	
Arteriosclerosis	?
Chronic myocarditis	?

Name of operation ___ Date of ___

What test confirmed diagnosis? Clinical Exam Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of Injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ___

(Signed) H. Wheeler M. D.

(Address) Cumberland Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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SEP 8 1939
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07629

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 27 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Bowman Addition
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JAMES M. JOHNSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Simons
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 3, 1912

8. AGE: Years	Months	Days	If less than one day
27	7	7	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: W. P. A.
11. Industry or business:

FATHER
12. Name: James Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Rummer
15. Birthplace: Maryland

16. Informant: Mrs. Mary Simons
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 39 (month) (day) (year)
Cemetery or crematory: Jea Vine Run Lutheran Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19 Aug 12, 19 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: aug 9 - 39 19 , at 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 1 - 39 19 , to aug 9 - 19 39 , and that I last saw h alive on aug 9 - 39 19 .

Immediate cause of death: acute Bacterial Endocardit — DURATION: 2 mont

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: acute bact. Endocardit.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Alfred Van Arsdale M. D. or other
Address: Cumberland, md Date signed: Aug 11 1939

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

07630

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 432 Grand Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Joyce

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Still-born. 8/24/39

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Paul Joseph Joyce

13. Birthplace Cumberland, Md.

MOTHER

14. Maiden name Ada Ruth Mason

15. Birthplace Portsmouth, Ohio

16. Informant Allegany Hosp.

Address Cumberland, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Disposed of by

Location hospital.

18. Funeral director

Address

19. Aug. 29, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1939, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at birth, to 19

and that I last saw h alive on 19

Immediate cause of death Still born (5 mos. pestation)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Bowen M.D. M. D. or other

Address Cumberland Md Date signed 8-29-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(119)

07631

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Hyndman Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Eugene Carl Kauffman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1939

8. AGE: Years: — Months: 5 Days: 29 If less than one day: hrs. min.

9. Birthplace: Hyndman, Pa. Bedford Co. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Carl Melvin Kauffman
13. Birthplace: Penna.

MOTHER
14. Maiden name: Florabell Shaffer
15. Birthplace: Penna.

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/3/39 (month) (day) (year)
Cemetery or crematory: Hyndman
Location: Hyndman Pa.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman Pa.

Aug 4 1939 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1939, 1:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1939, to Aug 1st 1939, and that I last saw h[im] alive on August 1st 1939.

	DURATION
Immediate cause of death: Acute Diarrhea	2 wks.
Due to: Feedings improperly prepared.	
Due to:	
Other conditions: Acidosis	3 days.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John A. Topper M.D. M. D. or other
Address: Hyndman Pa. Date signed 8-1-39.

RECEIVED
SEP 8 1933
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

07632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va County: Mineral

City or town: Wiley Ford Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME: Baby Girl Keplinger "A."

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Child.

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug 24, 1939

8. AGE: Years | Months | Days | If less than one day: 16 hrs. 30 min.

9. Birthplace: Wiley Ford, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Leo Keplinger
13. Birthplace: Petersburg W. Va.

MOTHER
14. Maiden name: Anna E. Newlen
15. Birthplace: Martinsburg W. Va

16. Informant: Leo Keplinger
Address: Wiley Ford W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26, 1939 (month) (day) (year)

Cemetery or crematory: Deavers Cem.

Location: Wiley Ford, W. Va.

18. Funeral director: Jacob Hafer.
Address: Cumberland, Md.

19. Aug. 25 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1939, at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1939, to Aug 25 1939, and that I last saw her alive on Aug 24 1939.

Immediate cause of death: Premature Infant 7 mos

Due to

Due to: Injury received by Mother in fall

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Allan E. Murray Md
M.D. or other

Address: 41 Green St Cumberland

Date signed: Aug 25 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (C) (T) W.Va

RECEIVED
SEP 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07633

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Wiley Ford. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME: Baby Girl Keplinger "B."

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug 24, 1939

8. AGE: Years | Months | Days | If less than one day: 12 hrs. ____ min.

9. Birthplace: Wiley Ford, Mineral, W. Va
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Leo Keplinger
13. Birthplace: Petersburg, W. Va

MOTHER
14. Maiden name: Anna E. Nevlen
15. Birthplace: Martinsburg W. Va

16. Informant: Leo Keplinger
Address: Wiley Ford W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26, 1939 (month) (day) (year)

Cemetery or crematory: Dequers Cem

Location: Wiley Ford, W. Va

18. Funeral director: Jacob Hafer
Address: Cumberland, Md.

19. Aug. 25 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1939, at 7:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1939, to Aug 25 1939, and that I last saw her alive on Aug 24 1939.

Immediate cause of death: Primatum Infant 7 mos

Due to

Due to: Injury received by Mother in fall

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: F. Alan G. Murray Ass
M. D. or other

Address: 41 Grove St Cumberland

Date signed: Aug 25 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M C T

W. Va

RECEIVED
SEP 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94E)

CERTIFICATE OF DEATH

07634

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 142 Frederick St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 142 Frederick St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry Harrison King

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Cora R. Dimmitt

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1884

8. AGE:

Years	Months	Days	If less than one day
55	1	11	hrs. min.

9. Birthplace Paw Paw, W. Va.
(Town, county, and state)

10. Usual occupation Parking Lot attendant

11. Industry or business

FATHER
12. Name John King
13. Birthplace Paw Paw W. Va.

MOTHER
14. Maiden name Mathilda Rowland
15. Birthplace Paw Paw W. Va.

16. Informant Walter N. King

Address Cumberland

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 20 39 (month) (day) (year)

Cemetery or crematory Camp Hill Cem.

Location Paw Paw W. Va.

18. Funeral director Innis Stein & Sons.

Address Cumberland

19. Aug. 19 1939 J. P. Franklin, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th 1939, at 7 P.M. 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death Coronary Thrombosis — DURATION one hour

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce H. Brown, M. D.
M. D. or other

Address Cumberland, Md. Date signed Aug 18-39

Deputy Medical Examiner Allegany

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 10

07635

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Mt Savage (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 2 wks

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Pa (b) County Somerset

(c) City or town Myersdale (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Infant Klink.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Still Born

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 - 1939

8. AGE: Years | Months | Days | If less than one day Still Born hr. min.

9. Birthplace Mt Savage Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Laurence W. Klink.

13. Birthplace Myersdale Pa

MOTHER

14. Maiden Name Angela C. Ludden

15. Birthplace Myersdale Pa.

16 (a) Informant Mrs L. W. Ludden

(b) Address Myersdale Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 - 39 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Mt Savage Md.

18 (a) Funeral director L. W. Klink (Father)

(b) Address Myersdale Pa.

19 (a) 8/3-39 (Date rec'd by registrar) (b) H. J. Bostetter M. D. Local Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 3 1939, at 6.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 19 .

Immediate cause of death Still Born

Due to Premature Birth 4½ mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 8/3-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107-a)

07636

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or insl. (yrs., or mos., or days) 3 days.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Bowman Addition.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Howard J. Lambert

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edna Dedrwick

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1870 ?

8. AGE: Years 69 | Months ? | Days | If less than one day ____ hrs. ____ min.

9. Birthplace (Town, county, and state): W. Va.

10. Usual occupation: Labour.

11. Industry or business: W. P. A.

FATHER
12. Name
13. Birthplace: Unknown

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Mrs Wm. Stein

Address: Springfield W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 39 (month) (day) (year)

Cemetery or crematory: Springfield W. Va

Location: Springfield W. Va.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Aug. 18, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-39 19__, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-12-39 19__, to 8-15-39 19__, and that I last saw him alive on 8-15-39 19__.

Immediate cause of death: Bronchial Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. Alfred Van Ohmer
M. D. or other

Address: Cumb. Md Date signed 8-17-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932 C

07637

CERTIFICATE OF DEATH

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 2 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State BENNA. County SOMERSET

City or town BERLIN Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 222 MAIN STREET
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME

MR. WALTER S. LANE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ELLEN TAYMAN

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 14 1854

8. AGE: Years 85 | Months 2 | Days 24 | If less than one day ____hrs. ____min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER
12. Name JACOB LANE
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden name MARY JANE HEFFORD
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Removal Date thereof Aug 9, 1939.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Berlin, Pa.

18. Funeral director Johnson & Son
Address Berlin, Pa.

19. Aug 8, 39 J. S. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 8, 1939 9:25PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 6, 1939, to AUG. 8, 1939, and that I last saw him alive on AUG. 8, 1939.

Immediate cause of death Bronchopneumonia
Chronic Nephritis,

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick J. Williams, M.D.
M. D. or other

Address 34 Va. Ave., Date signed 8/8/39

DR. DAUGHERTY

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 10

07638

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Mt Savage (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) Still Born

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State (b) County

(c) City or town Still Born (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Infant Loshley

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Still Born

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1939

8. **AGE:** Years Months Days If less than one day hr. min.

Still Born

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Benjamin H Loshley

13. Birthplace Md

MOTHER

14. Maiden Name Lilly M Norris

15. Birthplace Md

16 (a) Informant Benjamin H Loshley

(b) Address Mt Savage Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 1939 (month) (day) (year)

(c) Cemetery or crematory Methodist

Location Mt Savage Md

18 (a) Funeral director J. J. Kurz

(b) Address Frostburg Md

19 (a) 8/23/39 (Date rec'd by registrar) (b) H. J. Bostetter M.D. Local Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 23 1939 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw him alive on 19.

Immediate cause of death Still Born

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 8/23/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 2 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-2) Reg. Dist. No. 4

CERTIFICATE OF DEATH

07639

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Mead Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: National Pike Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 16 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Near Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. Narrows Park (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Frank P. Layton

3 (b) If veteran, name war
3 (c) Social Security No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Susan Layton
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1853

8. **AGE:** Years: 86 | Months: 8 | Days: 0 | If less than one day ____ hr. ____ min.

9. Birthplace Frostburg Road (Town, county, and state)
10. Usual occupation Retired Lumberman
11. Industry or business Saw Mill

FATHER
12. Name John Layton
13. Birthplace Frostburg Md

MOTHER
14. Maiden Name Susan Rosenbaker
15. Birthplace Near Frostburg Md

16 (a) Informant Robt. L. Heinz
(b) Address Cumberland Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 1939 (month) (day) (year)
(c) Cemetery or crematory Byard
Location Byard Wva

18 (a) Funeral director J. J. Hurst
(b) Address Frostburg Md

19 (a) Aug. 25, 1939 (Date rec'd by registrar) (b) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death 8/26/39 19___, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15/39 19___, to 8/26/39 19___, and that I last saw him alive on 8/26/39 19___.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Pt's Constitution weakened by age	
Due to Exfoliative dermatitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard J. Williams M.D. (M. D. or other)
Address 34 Va. Ave. Cumberland, Md. Date signed 8/28/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120)

07640

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Twiggtown Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Ward Leasure

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1936

8. AGE: Years 2 Months 4 Days 7 If less than one day hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Ward Leasure

13. Birthplace Md

MOTHER 14. Maiden name Myrtle Ammons

15. Birthplace W. Va.

16. Informant Ward Leasure

Address Twiggtown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8, 1939 (month) (day) (year)

Cemetery or crematory Davis Memorial

Location Oldtown Rd, Cumberland

18. Funeral director Louis Stein, Mgr.

Address Cumberland, Md

19. Aug 8, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1939, to Aug 6 1939, and that I last saw him alive on Aug 6 1939.

Immediate cause of death gastro-enteritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

[redacted] public place (where?)

Injured at work?

23. SIGNATURE Walter B. Johnson M. D. or other

Address Cumberland, Md Date signed Aug 7, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

07641

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 18 Fifth Street
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 18 Fifth Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth R Mangas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Charles H. Mangas
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1866

8. AGE: Years	Months	Days	If less than one day
72	9	0	hrs. min.

9. Birthplace Wellersburg, Penna
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home

FATHER
12. Name Daniel Beal
13. Birthplace ~~Unknown~~ Penna.

MOTHER
14. Maiden name Margaret Raley
15. Birthplace ~~Unknown~~ Penna

16. Informant Charles H. Mangas
Address 18 Fifth St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4, 1939 (month) (day) (year)
Cemetery or crematory Cook Cem
Location Wellersburg, Pa.

18. Funeral director Harvey H. Zeigler
Address Hyndman Penna.

19 Aug 8, 1939 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 1939, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 27 1938 to Aug 1 1939,
and that I last saw h~~e~~ alive on Aug 1 1939.

Immediate cause of death	DURATION
Myocarditis	?
Endocarditis	
Due to	
Due to	
Other conditions Chr. Nephritis	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. J. Lanich M. D. or other
Address Cumberland Md. Date signed 8/9/39

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (123)

Reg. Dist. No. 9

CERTIFICATE OF DEATH

03542

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg — Huffman Mines
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in this community (yrs., mos., or days) 55

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Frostburg — Huffman Mines
(If outside city or town limits, write RURAL and give town)

(d) Street No. Rural Huffman Mines
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Samuel B. McKenzie

3 (b) If veteran, name war —

3 (c) Social Security No. 213-09-6380

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Emma C. Croft

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 17 1884

8. **AGE:** Years 55 | Months 0 | Days 17 | If less than one day _____ hr. _____ min.

9. Birthplace Ailton, (Town, county and state) Md.

10. Usual occupation Stable Foreman

11. Industry or business Coal mines

FATHER

12. Name Charles L. McKenzie

13. Birthplace Md.

MOTHER

14. Maiden Name Lydia Wildon

15. Birthplace Md.

16 (a) Informant Mrs. Emma C. McKenzie

(b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7-1939 (month) (day) (year)

(c) Cemetery or crematory St. Anns

Location Garrett Co.

18 (a) Funeral director J. J. Dunn

(b) Address Frostburg Md

19 (a) 8-6-'39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 4 1939, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1939, to Aug 4 1939, and that I last saw him alive on Aug 4 1939.

Immediate cause of death	Duration
Ruptured Diverticulitis of Sigmoid Colon	2 Days
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations See above
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** W D McLaughlin M. D. (M. D. or other)

Address Frostburg Md Date signed Aug 6 1939

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 1 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

07643

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany County
City or town Cumberland, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days) 27 Days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 400 Decatur St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Campbell Pancake McNeill

3. (b) Social Security Number 217-10-7584

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elva Poling
6(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) July 8, 1904

8. AGE: Years 35 | Months | Days 31 | If less than one day ____ hrs. ____ min.

9. Birthplace Moorefield W. Va.
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business Kelly Fire Co.

FATHER
12. Name Benjamin McNeill
13. Birthplace Hardy Co. W. Va.

MOTHER
14. Maiden name Margaret Pearl McNeill
15. Birthplace Moorefield W. Va.

16. Informant Mrs Campbell McNeill
Address 400 Decatur St. Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10, 1939 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. Aug 9 1939 (Date received by registrar) Jos. S. Franklin (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7-1939 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-27-1939 to 8-7-1939 and that I last saw him alive on 8-7-1939

Immediate cause of death Cardiac Disease ? — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Not mail here.
Enlarged spleen
Of autopsy Spleen Enlarged

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Md. Date signed 8-8-39

RECEIVED
SEP 8 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07644

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegheny Co.
City or town: Westernport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 329 Hammond St.
Stay in hospital or Inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): all of life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegheny
City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 329 Hammond St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Eliza Elmira (Mollie) Michael

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1863

8. AGE:

Years	Months	Days	If less than one day
76	1	9	hrs. min.

9. Birthplace: (Near) Westernport
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business
FATHER
12. Name: George Lewis Michael
13. Birthplace: (Near) Westernport
MOTHER
14. Maiden name: Rebecca Jenkins
15. Birthplace: New Germany, Md.
16. Informant: Lola Ruth Michael
Address: Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23 1939 (month) (day) (year)
Cemetery or crematory: Rules
Location: Westernport, Md.
18. Funeral director: D. S. Beal
Address: Westernport, Md.
19. Aug. 22 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21 1939, at 7:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1939, to Aug 21 1939, and that I last saw h[illegible] alive on Aug 21 1939.

	DURATION
Immediate cause of death: Broncho-Pneumonia	8/15/39
Due to: Myocardial Weakness	
Due to:	
Other conditions: Stroke	June-39

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E Berry M.D.
M. D. or other
Address: Piedmont W. Va. Date signed: 8/24/39

RECEIVED
SEP 5 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07645

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 411 Independence Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 65 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 411 Independence St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JOHN P. MINNICKS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Cecelia McConnell
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 25, 1874

8. AGE: Years	Months	Days	If less than one day
65	1	3	hrs. min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)
10. Usual occupation: Policeman
11. Industry or business: Cumberland, Md.
FATHER 12. Name: Paulus Minnicks
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Lauderbach
15. Birthplace: Germany
16. Informant: Mr. Louis Minnicks
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 31, '39 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
C. Aug. 31, 19 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28, 1939, at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16, 1939, to Aug. 28, 1939, and that I last saw him alive on August 28, 1939
Immediate cause of death: Carcinoma of stomach — DURATION: 6 mo.
Due to:
Due to:
Other conditions: Carcinomatosis — 1 mo.
(Include pregnancy within 3 months of death)
Major findings:
Of operations: Carcinoma stomach cardiac end
Of autopsy: No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (Where?):
Means of injury: Injured at work?

23. SIGNATURE: C. C. Zimmerman M. D. or other
Address: Cumberland Md. Date signed 8-29-39

John P. Minnicks

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07646

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 hours

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 769 Fayette St.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR:

3. (a) FULL NAME: SAMUEL MORGAN

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 15, 1868

8. AGE: Years: 70 Months: 10 Days: 20 If less than one day ____ hrs. ____ min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Clothing Merchant

11. Industry or business: Retired

FATHER
12. Name: Jacob Morgan
13. Birthplace: Russia

MOTHER
14. Maiden name: Chippe Morgan
15. Birthplace: Russia

16. Informant: Memorial Hospital

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7 1939 (month) (day) (year)

Cemetery or crematory: East View Cemetery

Location: Cumberland, Md

18. Funeral director: V. L. Lemperenr.

Address: Cumberland, Md.

19. Aug 7 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5, 1939, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1939, to August 5 1939, and that I last saw him alive on August 5 1939.

Immediate cause of death: Right sided Heart Failure — DURATION: 1 day

Due to: Collapse Mid Lobe at Lung.

Due to: Metastatic Carcinoma Lungs

Other conditions: Carcinoma of Rectum
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel M. Jackson M.D. M. D. or other

Address: 119 Bedford St. Date signed: 8/6/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07647

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days): 5
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND, MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: ALLEGANY COUNTY HOME
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME
MR. MICHAEL NEWMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1851

8. AGE:

Years	Months	Days	If less than one day
88	—	—	hrs. min.

9. Birthplace: PENNSYLVANIA
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: THOMAS NEWMAN
13. Birthplace: EUROPE

MOTHER
14. Maiden name: ANNA WARD
15. Birthplace: EUROPE

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial Date thereof Aug 24 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Pat. Cem.
Location Cumberland, Md

18. Funeral director: Louis Stein Sue.
Address Cumberland Md

19. Aug. 24 39 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 23, 1939, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1939, to AUG. 23, 1939, and that I last saw him alive on AUG. 23, 1939.

Immediate cause of death: Carcinoma of thyroid gland — DURATION: ?
Due to:
Due to:
Other conditions: None
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Wm. F. Williams
M. D. or other
Address: Cumberland Date signed 8/24/39

DR. W. F. WILLIAMS

RECEIVED
SEP 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07648

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 mo - 17 days

Stay in this community (yrs., or mos., or days): 1 mo - 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 310 Bellvue Terrace (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ronald Edward Nichols

3. (b) Social Security Number

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 27, 1939

8. AGE: Years | Months: 1 | Days: 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland, Allegany, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Robert Gibson

13. Birthplace: Not known

MOTHER

14. Maiden name: Norma Jones

15. Birthplace: Myersdale, Pa.

16. Informant: Minnie Jones

Address: 310 Bellvue Terrace.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: ~~July~~ Aug 16, 1939 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Myersdale, Pa.

18. Funeral director: Jacob Hofer

Address: 230 Baltimore Ave Cumberland, Md.

19. Aug 16 1939 (Date rec'd by registrar) Jos. B. Franklin Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1939, at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1939, to Aug 16 1939, and that I last saw him alive on Aug 14 1939.

Immediate cause of death: Acute Gastro Enteritis — DURATION: 8-13-39

Due to: Chronic Gastro Enteritis — 6-27-39

Due to: Prematurity (About 33 wks gestation) — 6-27-39

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Arthur T. Jones M.D. M. D. or other

Address: 40 N. Liberty St. Date signed: Aug 16, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07649

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 714 Fayette St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7417 Fayette St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jesse J Parlaman

3. (b) Social Security Number: 192-03-6333

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Ida Smith Parlaman

6(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Aug 30 1885

8. AGE:

Years	Months	Days	If less than one day
54	11	7	hrs. min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Salesman.

11. Industry or business: Gold metal Flour.

FATHER 12. Name: Leo Parlaman.

FATHER 13. Birthplace: Md

MOTHER 14. Maiden name: Caroline Collins

MOTHER 15. Birthplace: Md.

16. Informant: Mrs Jesse Parlaman.

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9. 39 (month) (day) (year)

Cemetery or crematory: Mt Hermon.

Location: near Cumberland, Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Aug 8, 1939 (Date received by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1939, at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1937 to 8-7-1939 and that I last saw him alive on 8-6 1939.

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Portal Cirrhosis ?	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None.

Of autopsy: None.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed 8-7-39

Mr. Williamson
Jeffrey J. Parkinson

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

(59)

07650

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 150 E Main St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 70 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg Md
(If outside city or town limits, write RURAL and give town)

(d) Street No. 150 E. Main St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Annie Price Prichard

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Enoch Prichard

6. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1862

8. AGE: Years 76 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Lonaconing, Allegany, Md
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business "

FATHER
12. Name John Price
13. Birthplace England

MOTHER
14. Maiden Name Mary Lewis
15. Birthplace Mt. Savage

16 (a) Informant Enoch Prichard
(b) Address 150 E. Main St. Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery
Location Frostburg, Md

18 (a) Funeral director Jacob Hafer
(b) Address Frostburg, Md.

19 (a) 8-31-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 29 1939, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939, to Aug 29 1939, and that I last saw ~~him~~ her alive on Aug 29 1939

Immediate cause of death	Duration
Arteriosclerosis	? ?
Senility	
Due to Diabetes	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. D. McLane Jr. M.D.
M. D. or other

Address Frostburg Md Date signed Aug 31-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1939
BUREAU U. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

07651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 8 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edna Rinker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6 (b) Name of husband or wife Dallas Rinker

6(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) December 13, 1900

8. AGE: Years	Months	Days	If less than one day
38	7	17	hrs. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Hanlin

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden name Sarah Cosner

MOTHER 15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/39 (month) (day) (year)

Cemetery or crematory Philos Cem.

Location Westernport, Md.

18. Funeral director Paul S. Boal,

Address Westernport, Maryland

19. Sept. 1, 1939 (Date rec'd by registrar) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1939, at 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1939, to Aug 30 1939, and that I last saw h alive on Aug 30 1939.

	DURATION
Immediate cause of death Shock following Resection for intestinal obstruction	1 day
Due to	
Due to Ruptured gangrenous appendicitis with peritonitis	13 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations Gangrenous appendix ruptured

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other

Address Cumberland Md. Date signed 8-30-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120) CB

07652

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County Cambria

City or town Johnstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 654 Cyprus ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World War

3. (a) FULL NAME Robert Russell

3. (b) Social Security Number 196-07-8950

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Blanche Walker Russell

6(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Nov. 7th 1889

8. AGE:

Years	Months	Days	If less than one day
49	9	4	hrs. min.

9. Birthplace Lonaconing, Md.
(Town, county, and state)

10. Usual occupation Steel Worker

11. Industry or business U.S. Steel Co.

FATHER
12. Name Isaac Russell
13. Birthplace England

MOTHER
14. Maiden name Grace Emerson
15. Birthplace England.

16. Informant Mrs. Blanche Russell
654 Cyprus ave.
Address Johnstown, Pa.

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof Aug. 13 1939
(month) (day) (year)

Cemetery ~~or crematory~~ Grand View

Location Johnstown Penna.

18. Funeral director Carl Davis.

Address Johnstown, Pa.

19. Aug. 11 1939 Dr. E. Don Tylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1939, at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19 ——, to ——— 19 ——,

and that I last saw h— alive on ——— 19 ——.

Immediate cause of death
acute gastro enteritis
Sick about two hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other

Address Lonaconing Md Date signed Aug. 11 '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 28 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07653

53-E

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 607 Maryland Ave

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 607 Maryland Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ella Carleton Sellers

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced married

6 (b) ~~Name~~ of husband ~~or wife~~ George Sellers

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) March 8 1885

8. AGE: Years 54 Months 5 Days 7 If less than one day ___ hrs. ___ min.

9. Birthplace North Branch, Md
(Town, county, and state)

10. Usual occupation Home

11. Industry or business —

FATHER
12. Name High
13. Birthplace Md

MOTHER
14. Maiden name Pollock
15. Birthplace Md

16. Informant George Sellers

Address 607 Maryland Ave.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Aug 13, 1939
(month) (day) (year)

Cemetery or crematory Rose Hill Crept

Location Cumberland, Md

18. Funeral director Louis Stein Inc

Address 117 Fredrick St

19. Aug. 12 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11- 1939, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-6- 1939 to 8-11- 1939, and that I last saw her alive on 8-11- 1939.

Immediate cause of death Adenocarcinoma (metastatic)

DURATION

Due to Source of original

Due to growth undetermined.

Primarily, a small growth on the outer side of the left thigh, which was removed. C.W.G.R.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Shortly after, a metastasis to the glands of the groin; later, within the abdomen.

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm F. Williams
M. D. or other

Address Cumberland Date signed 8-12-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

07654

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 221 Harrison St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 221 Harrison St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rev. Eugene Pierre Skyles

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Johnson

6(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1870

8. AGE: Years 69 Months 6 Days 10 If less than one day ___ hrs. ___ min.

9. Birthplace Schellsburg, Bedford, Pa.
(Town, county, and state)

10. Usual occupation Preacher (Minister)

11. Industry or business Reformed Church

FATHER
12. Name Nehimiah Heckerman
13. Birthplace Martinsburg, Pa.

MOTHER
14. Maiden name Elizabeth Nicum
15. Birthplace Schellsburg, Pa.

16. Informant Mrs Perry Everstein
Address 3073 Dwight Ave. Dormont Pa.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 1, 1939 (month) (day) (year)

Cemetery or crematory Odd Fellows

Location Berlin Pa

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. Sept. 1, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8. 29. 1939, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11. 15. 1926, to 8. 29. 1939, and that I last saw h~~im~~ alive on 7-28- 1939.

Immediate cause of death: Coronary Krombosis

DURATION: ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-C (CB)

07655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.VA. County MINERAL
City or town BURLINGTON Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME
MISS. MARY SLOAN

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 25, 1873

8. AGE: Years	Months	Days	If less than one day
65	8	21	hrs. min.

9. Birthplace OHIO (Town, county, and state)
10. Usual occupation HOUSE WORK AT HOME
11. Industry or business

FATHER
12. Name JOHN SLOAN
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name EMILY STIMMEL
15. Birthplace OHIO

16. Informant ELIZA SLOAN
Address BURLINGTON, W.VA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 17, 1939 (month) (day) (year)
Cemetery or crematory Sloan Cemetery
Location Burlington W Va.
18. Funeral director J H Markwood Sons
Address Keyser W Va

Aug. 17, 1939 (Date filed by registrar) J. P. Franklin, M.D. Registrar

DR. HAWKINS

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 16, 1939 19 A.M. at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1939, to Aug 16 1939 and that I last saw her alive on Aug 16 1939

Immediate cause of death — DURATION

Due to Concussion of Sigmoid with intestinal obstruction

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A E Enfield M. D. or other
Address Cumberland, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 8 1939
BUREAU V. S.

07656

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(22)

Reg. Dist. No. 6

1. PLACE OF DEATH

County Alleganey

City or town Western port

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days) 2 hrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Piedmnot, Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3 Mi. West of Piedmont, W.Va.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME James Edward Stump

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1939.

8. Years	Months	Days	If less than one day
		5	hrs. min.

9. Birthplace Piedmont, Rural. Mineral, W.va (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name James S. Stump

13. Birthplace unknown

MOTHER 14. Maiden name Roxie Nicholis

15. Birthplace Ronceverte, W.Va.

16. Informant Anna Lee Brummage

Address Cross, W.Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug, 15, 1939 (month) (day) (year)

Cemetery or crematory Cross Cem.

Location Cross, W. Va

18. Funeral director D.S.Boal.

Address Westernport, Md.

19. Aug 14 1939 (Date rec'd by registrar) A J Zumbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1939 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1939, to Aug 13 1939, and that I last saw him alive on Aug 13 1939.

Immediate cause of death Tetanus — DURATION 8-13-39

Due to Infection of Cord Stump — 8-10-39

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J Norman Reeves M D M. D. or other

Address Westernport Md Date signed 8-14-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M C W.Va

RECEIVED
SEP 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH

119

07657

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Eckhart
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Eckhart
(If outside city or town limits, write RURAL and give town)

(d) Street No. —
(If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Josephine V. Trusk

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5-1939

8. **AGE:** Years — | Months 3 | Days 17 | If less than one day — hr. — min.

9. Birthplace Eckhart-alleg-md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Anthony Trusk
13. Birthplace Austria

MOTHER
14. Maiden Name Lavina Foster
15. Birthplace Eckhart md

16 (a) Informant Lavina Foster
(b) Address Eckhart

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23-1939 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St Michaels
Location Frostburg

18 (a) Funeral director J. J. Dunigan
(b) Address Frostburg

19 (a) 8-22-39 (Date rec'd by registrar) (b) mrs. A. B. Naylor Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 22 1939, at 10 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1939, to Aug 22 1939; and that I last saw him alive on Aug 22 1939.

Immediate cause of death Acute Infectious Gastro-Enteritis — Duration 7 days

Due to —

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature W. E. Gattens M.D. (M. D. or other)

Address Frostburg, Md. Date signed 9/22/39.

VS. 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 1 1939
BUREAU V. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (51-A)

Reg. Dist. No. 6

CERTIFICATE OF DEATH

07659

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Potomac Park (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Potomac Park (If outside city or town limits, write RURAL and give town)

(d) Street No. P (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Albert Jackson Werner

3 (b) If veteran, name war —

3 (c) Social Security No. does not have

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eva McKenzie

6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct 25-1895

8. AGE: Years 44 Months 9 Days 25 If less than one day hr. min.

9. Birthplace Finzel, Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Wm H. Werner

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Bell Stover

15. Birthplace Pa.

16 (a) Informant John Werner

(b) Address Finzel, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 22 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Greenville Pa

Location

18 (a) Funeral director J. J. Durst

(b) Address Swanton, Md.

19 (a) 8/21-9 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death 8-19- 1939, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12-1939, to 8-19-1939 and that I last saw him alive on 8-19-1939

Immediate cause of death Carcinoma of left kidney with

Due to general carcinomatosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm J Williams M. D. or other

Address Cumberland Date signed 8-21-39

RECEIVED
SEP 7 1938

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

07660

Reg. Dist. No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 76 Greene Street
Stay in hospital or inst. (yrs., or mos., or days): --
Stay in this community (yrs., or mos., or days): 22 ~~30~~ yeras

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 76 Greene Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: ERMANDA C. WHITMAN

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: W. Floyd Whitman
6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): December 5, 1881

8. AGE: Years	Months	Days	If less than one day
57	7	29	---hrs. ---min.

9. Birthplace: Marlington, West Virginia (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: at home

FATHER
12. Name: Armstead Combs
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Hannah M. Waugh
15. Birthplace: West Virginia

16. Informant: W. Floyd Whitman
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7, 1939 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Aug. 7, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

D. W. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-5-1939, at 2/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10.10. 1938 to 8.5. 1939 and that I last saw h-er alive on 8.4. 1939.

Immediate cause of death	DURATION
Carcinomatosis of Abdomen	
Due to Granulad Carcinoma of Cervix.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: See above
Oper: 10.10.38.
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dan. F. Williams M. D. or other
Address: 122 So. Centre Date signed: 8-5-39

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-e)

Reg. Dist. No. 9

07661

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Midlothian Road

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany R.F.D.

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. Midlothian Rd. Rural (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Joseph H. Whitstone

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Katherine Whitstone

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) July 11 - 1858

8. AGE: Years 81 Months 1 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Frostburg - Allegany - Md. (Town, county, and state)

10. Usual occupation retired

11. Industry or business brick layer

FATHER 12. Name Joseph H. Whitstone

13. Birthplace Md.

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mrs Joseph Whitstone

(b) Address Frostburg, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug 18 - 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany

Location Frostburg

18 (a) Funeral director J. J. Durst

(b) Address Frostburg Md.

19 (a) 8-18-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death August 15 1939, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1939, to 8-15 1939, and that I last saw him alive on 8-15 1939.

Immediate cause of death	Duration
Chronic myocarditis	3 yrs.
Due to Rheumatoid arthritis	5 yrs.
Due to arterio Sclerosis	
Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Diehl M.D. M. D. or other

Address Frostburg, Md. Date signed 8-17-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 1 1939
BUREAU V. S.

Outside of City limits

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

07662

(8)

1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. R3 Valley Rd St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Stillborn Wilson — If U. S. Veteran, specify WAR ...

(a) Residence: No. ... St., ... Ward. ... If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, dey, and yeer) Aug 27-1939

7. AGE Years	Months	Deys	If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trede, profession, or perticular kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc. —

10. Dete deceesed lest worked et this occupation (month and year) ...

11. Totel time (yeers) spent in this occupation ...

12. BIRTHPLACE (city or town) Valley Rd Cumberland R3
(Stete or country)

FATHER

13. NAME Ersel Wilson

14. BIRTHPLACE (city or town) Md
(State or country)

MOTHER

15. MAIDEN NAME Dorothy M Smyker

16. BIRTHPLACE (city or town) Md
(Stete or country)

17. INFORMANT Ersel Wilson
(Address) Cumberland R3

18. BURIAL, CREMATION, OR REMOVAL
Piece Mt. Savage, Md Date Aug. 27, 1939

19. UNDERTAKER Family - Ersel Wilson
(Address) Cumberland, Md.

20. FILED Aug. 28, 1939 J. P. Franklin M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug 27
(Month) (Dey) , 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1939, to Aug 27, 1939

I last saw h... alive on ..., 19...; death is said to have occurred on the date stated above, at ...m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Stillbirth	
Hydrocephalus	
Other Contributary Causes of Importence:	
Died on Aug 27 39	
Born Aug 27-39	

Neme of operation ... Dete of ...

What test confirmed diagnosis? ... Was there an eutopsy?

23. If deeth wes due to externel causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Dete of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury ...

Nature of injury ...

24. Was disease or injury in any wey releted to occupetion of deceesed? ...

If so, specify ...

(Signed) H. Allen Gelson M. D.

(Address) 41 Emmert Terrace

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

07663

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State W Va (b) County Mineral
(c) City or town Ridgeley W Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Mineral St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Wilson

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19-1939

8. AGE: Years — Months — Days — If less than one day — hr. — min.

9. Birthplace Cumberland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Kenneth Wilson
13. Birthplace Cumberland

MOTHER
14. Maiden Name Margaret Wilson
15. Birthplace Kitzmiller Md

16 (a) Informant Mrs Frank Wilson
(b) Address 13 Mineral St Ridgeley W Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22/39 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Cumberland Md

18 (a) Funeral director William H. Kight
(b) Address Cumberland Md

19 (a) Aug. 21 1939 (Date rec'd by registrar) (b) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 19 1939, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1939, to Aug. 19 1939, and that I last saw him alive Still born 8/19 1939.

Immediate cause of death Still born 3 Month failure.

Due to Unable to State

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. F. W. Sinyer M. D. or other
Address Cumberland Md Date signed 8-21-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 4

07664

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 209 Knox St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Knox St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Clara Wilt

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walter Wilt

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 4/22/1887

8. AGE: Years 52 Months 4 Days 2 If less than one day hr. min.

9. Birthplace Romney WVa (Town, county, and state)

10. Usual occupation House duty

11. Industry or business Own House

FATHER
12. Name Samuel Simmons
13. Birthplace Pennelton County WVa

MOTHER
14. Maiden Name Mary Saville
15. Birthplace Pleasant Dale WVa

16 (a) Informant Mrs Sallie Corbin
(b) Address Romney WVa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/39 (month) (day) (year)
(c) Cemetery or crematory Cedarwood Cemetery
Location Cumberland, Md

18 (a) Funeral director Wm H Right
(b) Address Cumberland Md

19 (a) Aug 26 1939 (Date rec'd by registrar) (b) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 24 1939, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1939, to Aug 24 1939, and that I last saw him alive on Aug 24 1939.

Immediate cause of death	Duration
Chronic nephritis	6 mos
Due to Uremic Coma	6 hours
Due to Arteriosclerosis	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D. or other
Address Cumberland Md Date signed

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07665

Reg. Diat. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 33 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County All.
City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 31 West Main Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Stewart Workman

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife Alpheus G. Workman
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10. 1860

8. AGE: Years	Months	Days	If less than one day
79	4	11	hrs. min.

9. Birthplace Kirkintilloch Scotland
(Town, county, and state)
10. Usual occupation Housework.
11. Industry or business Own Home.
FATHER 12. Name George Stewart
13. Birthplace Kirkintilloch Scotland
MOTHER 14. Maiden name Elizabeth Henry
15. Birthplace Kirkintilloch, Scotland
16. Informant Wm. Jeffrey.
Address Lonaconing Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24. 1939 (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Lonaconing Md.
18. Funeral director David S. Boal
Address Lonaconing Maryland
19 Aug. 23 1939 (Date rec'd by registrar) Dr. E. Van Lear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1939, at 5-30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1939, to Aug 21 1939, and that I last saw h alive on Aug 12 1939.
Immediate cause of death Angina Pectoris — DURATION about 1 year
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M D
M. D. or other
Address Lonaconing, Md. Date signed Aug. 22-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 5 1939
BUREAU V. S.

Outside of City Limits

INCORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46-C)

Reg. Dist. No. 4

07658

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town La Vale (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 7 Mos.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town La Vale (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Agnes McMillan Young

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Daniel Young

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 7, 1859

8. AGE: Years 79 Months 10 Days 6 If less than one day ____ hr. ____ min.

9. Birthplace Vale Summit, Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER

12. Name Hugh McMillan

13. Birthplace Scotland

MOTHER

14. Maiden Name Margaret Smith

15. Birthplace Scotland

16 (a) Informant Mr. Ferd. Ravenscraft

(b) Address Lonaconing, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1939 (month) (day) (year)

(c) Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18 (a) Funeral director W. Eichhorn

(b) Address Lonaconing, Md.

19 (a) Aug 15, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death August 13 1939, at 11:45 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to Aug 13 1939, and that I last saw him alive on Aug 12 1939.

Immediate cause of death	Duration
Exhaustion and Starvation	[illegible]
Due to Carcinoma of Caecum	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Allan G. Murray M.D. M. D. or other

Address 41 Green St Cumberland Md Date signed Aug 15/39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1939
BUREAU V. S.